Community Health Center Chronic Disease Teams "Health Care Practices"

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ADHS Chronic Disease Disparities in Arizona:
From Awareness to Action
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Pacific West Health Disparities Collaborative (PWHD) State by State Analysis

- Currently Arizona has 1 CHC *"United Community Health Center"* in Phase I
- 11 CHCs in Phase II
- 3 potential teams

CHC Participation in Health Care Practices

- Canyonlands Community Health Center HDC "2004"
- Chiricahua Community Health Center HDC "2003"
- Clinica Adelante HDC "2004"
- Desert Senita Community Health Center HCD "2003"
- El Rio Health Center HDC "2003"
- Marana Health Center HDC "2002" - CVD

CHC Participation in Health Care Practices

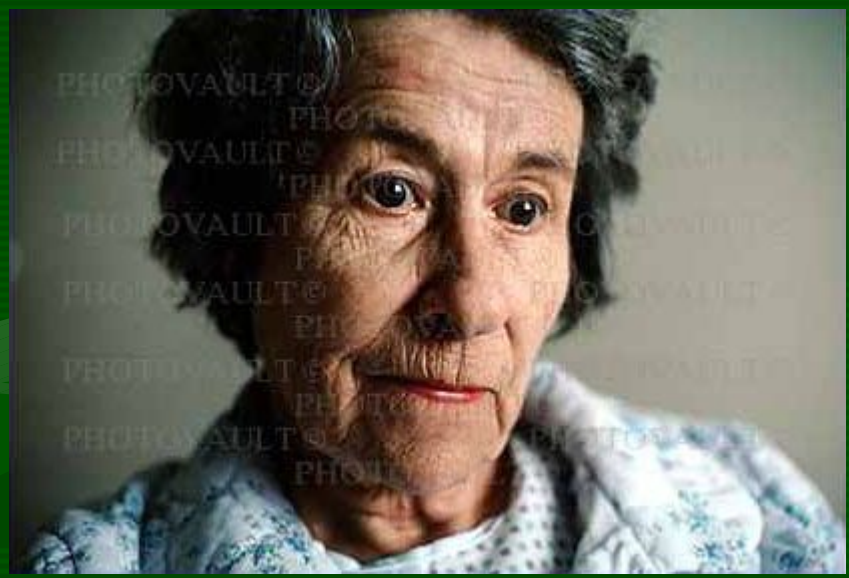
- Maricopa County Health Care for the Homeless HDC "2001"- CVD
- Mariposa Community Health Center HDC "2000"
- Mountain Park Health Center HDC "2001"- AST
- North Country Community Health Center HDC "2003"
- Sun Life Family Health Center HDC " 2002"
- United Community Health Center HDC "2005"

Extended Collaborative Teams

- BPHC Chronic Disease Health Disparities Collaboratives *"Pacific West Health Disparities Collaborative"*
- AZ State Diabetes Collaborative
- Health Services Advisory Group "Partners in Quality"

A sad soul can kill you quicker than a germ.

John Steinbeck



Best Practice models "Elements of the Care Model: Asthma"

Self-Management	Decision Support	Clinical Information System	Delivery System Design	Organization of Health Care	Community
Use asthma self-management education and tools that are based on evidence of effectiveness, such as an Asthma Action Plan (AAP).	Embed evidence-based guidelines in the care delivery system. *Use easily accessible flow sheets, pathways or checklist.* Include the use of a structured assessment to diagnose and determine severity of all patients.	Establish a registry.	Use the registry to proactively review care and plan visits. (See Clinical Information System.)	Make improving chronic care a part of the organization's vision, mission, goals, and performance improvement and business plans.	Establish linkages with organizations to develop support programs and policies.
Set and document self-management goals collaboratively with patients.	Establish linkages with key specialists to assure that primary care providers have access to expert support.	Develop processes for use of the registry, including designating personnel for data entry, assuring data integrity, and registry maintenance.	Assign roles, duties, and tasks for planned visits to a multidisciplinary care team. Use cross-training to expand staff capability.	Make sure senior leaders and staff visibly support and promote the effort to improve chronic care.	Link to community resources for defrayed medication costs, education, and materials.
Train providers and other key staff on how to help patients with self-management goals	Provide skill-oriented interactive training programs for all staff in support of chronic illness improvement, *including case studies.*	Use the registry to generate reminders and care-planning tools for individual patients.	Use planned visits in individual and group settings.	Make sure senior leaders actively support the improvement effort by removing barriers and providing necessary resources	Encourage participation in community education classes and support groups.
Follow up and monitor self-management goals and Asthma Action Plans.	Educate patients about guidelines. (See Self-Management.)	Use the registry to provide feedback to care team and leaders about *results and outcomes of care effectiveness over time and across providers and populations.*	Make designated staff responsible for follow-up by various methods, including outreach workers, telephone calls, and home visits.	Assign day-to-day leadership for continued clinical improvement	Raise community awareness through networking, outreach, and education
Use group visits to support self-management.	*Routinely review literature for improved guidelines for meds and treatments and update materials.*		Assure that appointment systems support the needs of asthma patients for urgent visits.	Integrate Collaborative Models into the Quality Improvement program	Provide a list of community resources to patients, families, and staff.
Tap community resources to achieve self-management goals. (See Community.)			*Create an asthma toolkit/center where all the devices, tools, sample meds, paperwork, educational materials, guidelines and forms that are needed to see an asthma patient.*	*Senior leader is part of the process improvement team*	*Establish connections to local hospitals to improve information flow for asthma.*
Use specific strategies in appropriate languages to help patient manage conditions; spend time speaking with patients to understand what matters to them.			*Create a mechanism to identify charts for patients with asthma*		
Provide spacers, peak flow meters and other equipment as needed.					
Address environmental and lifestyle issues/choices i.e. smoking cessation programs, mattress covers, asthma triggers.					

CHCs in the Asthma Collaborative

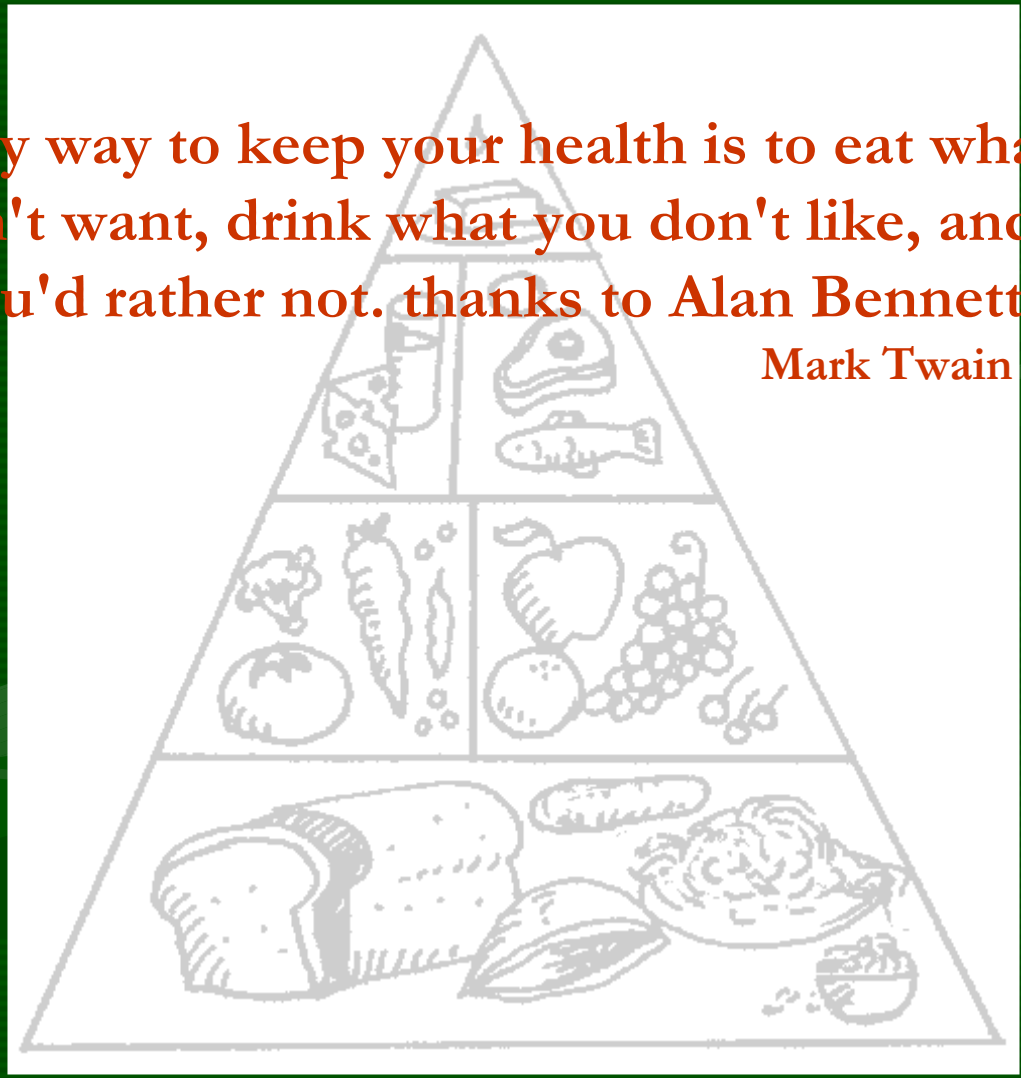
- Mountain Park Community Health Center
- Clinica Adelante Community Health Center
- Canyonlands Community Health Center

Best Practice models "Elements of the Care Model: Diabetes"

Self-Management	Decision Support	Clinical Information System	Delivery System Design	Organization of Health Care	Community
Use diabetes self-management tools that are based on evidence of effectiveness	Embed evidence-based guidelines in the care delivery system.	Establish a registry.	Use the registry to review care and plan visits	Make improving chronic care a part of the organization's vision, mission, goals, performance improvement and business plans.	Establish linkages with organizations to develop support programs and policies.
Set and document self-management goals collaboratively with patients	Establish linkages with key specialists to assure that primary care providers have access to expert support.	Develop processes for use of the registry, including designating personnel for data entry, assuring data integrity, and registry maintenance.	Assign roles, duties, and tasks for planned visits to a multidisciplinary care team. Use cross-training to expand staff capability.	Make sure senior leaders and staff visibly support and promote the effort to improve chronic care.	Link to community resources for defrayed medication costs, education, and materials.
Train providers and other key staff on how to help patients with self-management goals.	Provide skill-oriented interactive training programs for all staff in support of chronic illness improvement.	Use the registry to generate reminders and care-planning tools for individual patients.	Use planned visits in individual and group settings	Make sure senior leaders actively support the improvement effort by removing barriers and providing necessary resources.	Encourage participation in community education classes and support groups.
Follow up and monitor self-management goals. Use group visits to support self-management	Educate patients about guidelines	Use the registry to provide feedback to care team and leaders.	Make designated staff responsible for follow-up by various methods, including outreach workers, telephone calls, and home visits.	Assign day-to-day leadership for continued clinical improvement.	Raise community awareness through networking, outreach, and education.
Tap community resources to achieve self-management goals.			Use *promotoras* and community health worker programs for outreach.	Integrate Collaborative Models into the Quality Improvement program.	Provide a list of community resources to patients, families, and staff.

The only way to keep your health is to eat what you don't want, drink what you don't like, and do what you'd rather not. thanks to Alan Bennett

Mark Twain



CHCs in Diabetes Collaborative

- Canyonlands Community Health Center
- Chiricahua Community Health Center
- Clinica Adelante
- Desert Senita Community Health Center
- El Rio Health Center
- Marana Health Center
- Maricopa County Health Care for the Homeless
- Mariposa Community Health Center
- Mountain Park Health Center
- North Country Community Health Center
- Sun Life Family Health Center
- United Community Health Center

Best Practice models "Elements of the Care Model: Depression"

Self-Management	Decision Support	Clinical Information System	Delivery System Design	Organization of Health Care	Community
Use depression self management tools that are based on evidence of effectiveness	Embed evidence based guidelines in the care delivery system	Establish a registry	Identify depressed patients during visits for other purposes	Make sure senior leaders and staff visibly support and promote the effort to improve chronic care	Establish linkages with organizations to develop support programs and policies
Set and document self management goals collaboratively with patients	Establish linkages with key specialists to assure that primary care providers have access to expert support	Develop processes for use of the registry, including designating personnel to enter data, assure data integrity, and main the registry	Use the registry to proactively review care and plan visits	Make improving chronic care a part of the organization's vision, mission, goals, performance improvement, and business plans	Link to community resources for defrayed medication costs, education, and materials
Train providers and other key staff on how to help patients with self management goals	Provide skill oriented interactive training programs for all staff in support of chronic illness improvement	Use the registry to generate reminders and care planning tools for individual patients	Assign roles, duties, and tasks for planned visits to a multidisciplinary care team. Use cross training to expand staff capability	Make sure senior leaders actively support the improvement effort by removing barriers and providing necessary resources	Encourage participation in community education classes and support groups
Follow up and monitor self management goals	Educate patients about guidelines	Use the registry to provide feedback to care team and leaders	Use planned visits in individual and group settings	Assign day-to-day leadership for continued clinical improvement	Raise community awareness through networking, outreach, and education
Uses group visits to support self management			Make designated staff responsible for follow-up by various methods, including outreach workers, telephone calls and home visits	Integrate collaborative models into the quality improvement program	Provide a list of community resources to patients, families, and staff
Tap community resources to achieve self management goals			Use *Promotoras* and community health worker programs for outreach		

CHC's that Provide Behavioral Health

- El Rio Community Health Center
- Marana Community Health Center
- Mountain Park Community Health Center
- Desert Senita Community Health Center
- United Community Health Center
- Mariposa Community Health Center
- Native American Community Health Center

Best Practice models "Elements of the Care Model: Cardiovascular Disease"

Self-Management	Decision Support	Delivery System Design	Community	Organization of Healthcare	Clinical Info Systems
Develop culturally appropriate self-management approaches: Promotora/ community health worker; Group visits/support groups; Stages of change model/motivational interview	Develop systems/mechanisms to facilitate communication between PCP, specialist, and hospital	Provide alternative patient flow and visits (planned and group visits, drop in visits for BP checks)	Obtain free or discounted resources from pharmaceutical firms, service groups, health plans for scales, meds, BP cuffs and education programs	Senior leader to identify and allocate resources and remove barriers for implementation of improving chronic care in the system	Develop an electronic registry that can identify the center's CVD patients
Use of culturally/literacy appropriate education and self-management programs and materials (i.e.; smoking cessation and cooking classes)	Provider education: guidelines, BP technique and availability of patient education resources	Use of multidisciplinary care team (Nutritionist, social worker, exercise physiologist)	Promote non-traditional partnerships i.e. parks, transportation, health clubs, schools, YMCA, faith-based organizations, restaurants, barbers & beauty shops for places to exercise, monitor BP, healthy food	Develop partnerships with other health care organizations interested in patient care and outcomes	Cross train staff to enter data and track outcomes
Provide tools for self-management (scale, BP cuff, pedometer, etc)	Integrate guidelines into daily clinical practice (use of flowsheet, etc)	Relevant info available at the time of the visit	Work with homeless shelters, migrant camps to provide education, nutrition, BP checks	BOD and SL receive regular reports	Use of queries and reports proactively to treat patient and plan care
Patient tailored collaborative goal setting with form and follow-up – copy of goals to patient and medical record	Clinical guidelines adopted and used in the organization	Consistent and appropriate follow up including use of telephone, promotora etc.	Use of promotoras, community health workers, and the faith based community to reach out to the community for education and screening	Ensure that the Care Model is integrated into the strategic organizational plans	Provide information from registry to patient at time of visit
Protocols and training for staff relating to self management support	Provide feedback from population data to providers (results and compliance with guidelines and measures)	Assure clinical case management services for complex patients	Develop relationships with universities and their providers to place students and interns and for community projects Reach out to the community with health fairs and community education	Senior leader is engaged and endorses and communicates context and progress to BOD and staff	Establish real-time data entry process, including back up process
Organize and/or provide access to patient support groups	Use of standing orders and protocols, when appropriate	Identify CVD patient charts and utilize every opportunity to address CVD needs	Hospital and university linkages for specialty care	Collaborative team is empowered to make changes	Have IS person as part of team
	Inform patients about guidelines pertinent to their care	Reminders available and looked at ahead of time	Partner with state, local and community public health programs	Incorporate training in the models into the orientation of new employees/staff	Develop mechanism to determine the integrity of the data

CHCs doing CVD Collaborative

- Marana Community Health Center
- Maricopa County Health Care for the Homeless
- Desert Senita Community Health Center

Where are they now?
Future Plans

- AACHC data base
  - CHCs working closer together, sharing best practices, weaknesses and strengths.
  - Phase two teams to mentor phase one teams
  - Utilize community resources / collaborating offers better chances of higher results
- Over all effect state wide
  - Greater scoring
  - Grant opportunities
- Structure for success
  - Continue to share data/and other information
  - Commit to sustain / spread
  - Continue to use improvement methods

Teamwork represents a set of values that encourage behaviors such as listening and constructively responding to points of view expressed by others, giving others the benefit of the doubt, providing support to those who need it, and recognizing the interests and achievements of others.

Katzenbach & Smith

Unraveling The Mystery of Health: How People Manage Stress and Stay Well.

We are coming to understand health not as the absence of disease, but rather as the process by which individuals maintain their sense of coherence (i.e. sense that life is comprehensible, manageable, and meaningful) and ability to function in the face of changes in themselves and their relationships with their environment.

Aaron Antonovsky (1987).